RHODE ISLAND DEPARTMENT OF HUMAN SERVICES

Child Care Assistance Program (CCAP)

Child Care Assistance Application

This envelope means that you must send us proof for the question you are currently answering. Read the box beside the envelope to see what you must send.

If you need help completing this form, call 401-462-5300.

1.

APPLICANT NAME (Head of Household) Last First Initial	Social Security Number
PHONE NUMBER WHERE YOU CAN BE REACHED BETWEEN 8:30am - 4:00pm	☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Single
ADDRESS Number Street	City/Town State Zip Code
MAILING ADDRESS (if different)	

Please include proof of your residence in the form of a rent receipt, lease, utility bill, mortgage bill, or other shelter expense documentation.

2. Do you or any adult in your household speak English? ☐ Yes ☐ No

If no, what language(s) is spoken in your home? _____

3. Did you move to Rhode Island within the last three (3) months? ☐ Yes ☐ No

If YES, Date: _____ From where? _____

DHS will schedule an interpreter or bilingual staff member to help you read English language notices, letters or other written information from DHS. If you have problems obtaining interpreter or bilingual staff services at a DHS office, please contact the Limited English Proficiency Coordinator at (401) 462-2130 (for deaf/hearing impaired 462-6239 or 711).

OFFICE USE ONLY
Date Received

4. YOUR HOUSEHOLD: List every person who lives in your home now, whether you are asking for child care for that person, or not.

NAME	RELATIONSHIP TO YOU	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER (if you have one)	REQUESTING CHILD CARE?	IS THIS CHILD IN KINDER-GARTEN?	CITIZENSHIP STATUS	RACE* (see below) optional	Is this person's Ethnicity Latino/Hispanic? (optional)
Last First Initial	SELF/ Head of Household	☐Female ☐Male					U.S. Citizen? ☐ Yes ☐ No	☐ W ☐ B ☐ A ☐ N ☐ I	☐ Yes ☐ No
		☐Female ☐Male			☐ Yes ------> ☐ No	☐ Yes ☐ No	U.S. Citizen? ☐ Yes ☐ No	☐ W ☐ B ☐ A ☐ N ☐ I	☐ Yes ☐ No
		☐Female ☐Male			☐ Yes ------> ☐ No	☐ Yes ☐ No	U.S. Citizen? ☐ Yes ☐ No	☐ W ☐ B ☐ A ☐ N ☐ I	☐ Yes ☐ No
		☐Female ☐Male			☐ Yes ------> ☐ No	☐ Yes ☐ No	U.S. Citizen? ☐ Yes ☐ No	☐ W ☐ B ☐ A ☐ N ☐ I	☐ Yes ☐ No
		☐Female ☐Male			☐ Yes ------> ☐ No	☐ Yes ☐ No	U.S. Citizen? ☐ Yes ☐ No	☐ W ☐ B ☐ A ☐ N ☐ I	☐ Yes ☐ No
		☐Female ☐Male			☐ Yes ------> ☐ No	☐ Yes ☐ No	U.S. Citizen? ☐ Yes ☐ No	☐ W ☐ B ☐ A ☐ N ☐ I	☐ Yes ☐ No
		☐Female ☐Male			☐ Yes ------> ☐ No	☐ Yes ☐ No	U.S. Citizen? ☐ Yes ☐ No	☐ W ☐ B ☐ A ☐ N ☐ I	☐ Yes ☐ No
		☐Female ☐Male			☐ Yes ------> ☐ No	☐ Yes ☐ No	U.S. Citizen? ☐ Yes ☐ No	☐ W ☐ B ☐ A ☐ N ☐ I	☐ Yes ☐ No
		☐Female ☐Male			☐ Yes ------> ☐ No	☐ Yes ☐ No	U.S. Citizen? ☐ Yes ☐ No	☐ W ☐ B ☐ A ☐ N ☐ I	☐ Yes ☐ No
		☐Female ☐Male			☐ Yes ------> ☐ No	☐ Yes ☐ No	U.S. Citizen? ☐ Yes ☐ No	☐ W ☐ B ☐ A ☐ N ☐ I	☐ Yes ☐ No

Please provide copies of birth certificates or proof of INS Immigration status for all children for whom you are requesting child care assistance. If any child for whom you are requesting child care does not have a social security number, you must apply for one at the Social Security Office and provide us with verification that you have applied. If you have already verified this information because you receive FIP, Food Stamps, or Medical Assistance through DHS, you do not need to provide documentation of this information again.

*** Race**

Please place a check mark in the blocks above. You may check off more than one box for each person.

W = White
B = Black or African American
A = Asian
N = Native Hawaiian or Other Pacific Islander
I = American Indian or Alaskan Native

5. IMMIGRATION STATUS: Please write the name and immigration status for each child applying for Child Care who is not a US citizen.

Last Name	First	Initial	IMMIGRATION STATUS

IMMIGRATION STATUS

1. Legal permanent resident
2. Admitted as refugee
3. Granted asylum
4. Granted withholding of deportation
5. Granted conditional entry
6. Paroled into the US for at least 1 year
7. Cuban/Haitian entrant
8. Undocumented

If the child's immigration status is # 1-7 (above) proof of immigration status is required.

6. ABSENT PARENT(s): Are there child(ren) in the household who do not have both parents (natural or adoptive) living with them? ☐ Yes ☐ No

List as Absent Parent present or former husband for children born during that marriage, or within 10 months of a final decree of divorce from that husband. If divorce decree of court order excludes your husband or former husband as father of any of the child(ren) listed in the application, you need to list the biological father of the child(ren) and provide copies of the decree or order with this application. If there is more than one absent parent, or if you have more than three children with this absent parent, please copy the chart below, and attach on a separate page with the other absent parent's/parents' information.

Absent Parent's Last Name First Name Middle Initial	Sex ☐ M ☐ F	Absent Parent's Social Security No. ____/____/____	Absent Parent's Birth Date ____/____/____
Absent Parent's Current, or Last Known, Address			Absent Parent's Telephone Number
Is this parent deceased? ☐ Yes ☐ No If yes, date of death: ____/____/____	Employer Name and Address		Is this absent parent disabled and/or a Veteran? ☐ Yes ☐ No

Were the parents of the child(ren) married to each other? ☐ Yes ☐ No If yes, date married ____/____/____
Are the parents of the child(ren) currently married to each other? ☐ Yes ☐ No If no, date divorced ____/____/____

Child(ren) of the absent parent living in this household. Child's Last Name First Middle Initial	State of Birth	Is child support, health coverage, or paternity court ordered? (If yes, list date of court order.)		
1.		☐ Yes ☐ No	Support ☐ Health Cov ☐ Paternity ☐	Date_____ Date_____ Date_____
2.		☐ Yes ☐ No	Support ☐ Health Cov ☐ Paternity ☐	Date_____ Date_____ Date_____
3.		☐ Yes ☐ No	Support ☐ Health Cov ☐ Paternity ☐	Date_____ Date_____ Date_____

Do you have reason to fear this Absent Parent will cause harm to either you or your child(ren)? ☐ Yes ☐ No
At this time, do you want your Social Caseworker to make a referral for you, to the Domestic Violence Advocate? ☐ Yes ☐ No
Have you ever filed a Police Report about any incident with this Absent Parent, or requested a Restraining Order? ☐ Yes ☐ No
If so, provide a copy of the Restraining Order to your Social Caseworker, or call 222-7000 and ask for a Child Care Social Worker. If you answered "Yes" to any of these questions, fill out the AP-35-CCAP included with the cover pages for this packet, and return with this application.

7. JOB INCOME: Do you or anyone in the household have or expect to have income from a job this month?
☐ Yes ☐ No **Please tell us about self-employment income in Question 8.**

If yes, fill in the boxes below about the job. Please use a new page for a second job, or second parent with job.

Last Name First Initial	HOW OFTEN PAID? ☐ weekly ☐ every 2 weeks ☐ twice a month ☐ other: _____	DAY PAID: (circle one) Irreg S M T W Th F Sa
EMPLOYER NAME AND ADDRESS:	EMPLOYER PHONE: DATE HIRED/REHIRED:	JOB TITLE:

FROM YOUR PAY STUBS FOR THE LAST FOUR WEEKS, FILL IN THE BOXES BELOW:

PAY STUB #	DATE PAID	REGULAR HOURS	OVERTIME HOURS	GROSS WAGES BEFORE TAXES	TIPS/ COMMISSION	OTHER
1				$	$	$
2				$	$	$
3				$	$	$
4				$	$	$

Please include copies of pay stubs for the last four (4) weeks and a statement from your employer of the times and days that you work. Or, if this is a new job, or a return to the same job after an absence of three (3) weeks or more, and you don't have four (4) pay stubs, you must provide a letter from your employer indicating first day of work, hourly/weekly wages, times/days of work, and total hours of work per week. Example: "Works from 9:00 AM to 3:00 PM, Monday through Friday."

	Hours of Work Activity	
Work Schedule	Start Time	End Time
Sunday		
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		

Check Off the Statements that Apply to Your Job

☐ If new job, date job will begin _____/_____/_____

☐ This income will stop on (date) _____/_____/_____

☐ I work the same days of the week every week.

☐ I generally work the same number of hours each week.

☐ My work days change each: week / month (circle one)

☐ I rotate shifts each: week / month / other _____(circle one)

☐ I work overtime:
occasionally / whenever offered / other _____(circle one)

☐ I rely on public transportation to get to work.

☐ This job is seasonal and my hours will drop below 20/week.

☐ My job is during the school year with summers off.

☐ I am returning to the same job after an absence of three (3) weeks or more, and will return on (date) _____/_____/_____

If the second parent in your household or your spouse is also employed, or if you have a second job, use this new page for additional job information.

Last Name First Initial	HOW OFTEN PAID? ☐ weekly ☐ every 2 weeks ☐ twice a month ☐ other: _____	DAY PAID: (circle one) Irreg S M T W Th F Sa
EMPLOYER NAME AND ADDRESS:	EMPLOYER PHONE: DATE HIRED/REHIRED:	JOB TITLE:

FROM YOUR PAY STUBS FOR THE LAST FOUR WEEKS, FILL IN THE BOXES BELOW:

PAY STUB #	DATE PAID	REGULAR HOURS	OVERTIME HOURS	GROSS WAGES BEFORE TAXES	TIPS/ COMMISSION	OTHER
1				$	$	$
2				$	$	$
3				$	$	$
4				$	$	$

Please include copies of pay stubs for the last four (4) weeks and a statement from your employer of the times and days that you work. Or, if this is a new job, or a return to the same job after an absence of three (3) weeks or more, and you don't have four (4) pay stubs, you must provide a letter from your employer indicating first day of work, hourly/weekly wages, times/days of work, and total hours of work per week. Example: "Works from 9:00 AM to 3:00 PM, Monday through Friday."

	Hours of Work Activity	
Work Schedule	Start Time	End Time
Sunday		
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		

Check Off the Statements that Apply to Your Job

☐ If new job, date job will begin _____/_____/_____

☐ This income will stop on (date) _____/_____/_____

☐ I work the same days of the week every week.

☐ I generally work the same number of hours each week.

☐ My work days change each: week / month (circle one)

☐ I rotate shifts each: week / month / other _____(circle one)

☐ I work overtime:
occasionally / whenever offered / other _____(circle one)

☐ I rely on public transportation to get to work.

☐ This job is seasonal and my hours will drop below 20/week.

☐ My job is during the school year with summers off.

☐ I am returning to the same job after an absence of three (3) weeks or more, and will return on (date) _____/_____/_____

8. **SELF-EMPLOYMENT INCOME: Do you or anyone in your household have income from a self-owned business?** ☐ Yes ☐ No

Please tell us about any income from providing child care in Question 9.

Type of Income	Gross Income	How Often	Expenses	Will this income continue?	Name of person who gets this money
SELF EMPLOYMENT Type of Work? _____	$		$	☐ Yes ☐ No ☐ Unknown	

Please complete the following information about the days and hours spent working at a self-owned business.

Day	Start Time	End Time	Start Time	End Time	Start Time	End Time
Sunday						
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						

Please list all of your business income and business expenses:

Type of Income	Amount of Income	How Often*	Type of Expense	Amount of Expense	How Often*
1.				$	
2.				$	
3.				$	
4.				$	
5.				$	
6.				$	
7.				$	

* How often (weekly, biweekly, bi-monthly, monthly, quarterly, etc.)?

- All expenses must be documented with receipts or other verification.
- Allowable business expenses are those which are essential to producing or providing goods and services.
- Expenses may include, labor, material, supplies, taxes, overhead expenses, travel expenses, interest on loans to purchase equipment and other income-producing property.
- When a business is carried on at home, no part of the overhead is considered a business expense.
- Items such as depreciation, personal business and entertainment expenses, personal transportation, personal income taxes or retirement plans, charitable contributions, purchases of capital equipment, and payments on the principal of loans for capital assets or durable goods are not considered business expenses.

For each type of income listed above, include proof of gross income earned and related expenses, if any. If your business is incorporated, that should be indicated on your documentation. We will also accept a copy of your latest Federal Income Tax forms, which include the Profit and Loss Statement, or a Profit and Loss Statement from your accountant for the last three (3) months if your Federal Income Tax forms are over three (3) months old.

9. CHILD CARE INCOME: Do you or anyone in your household have income from providing child care for other children? ☐ **Yes** ☐ **No** If you are a self-employed child care provider, no payment will be authorized for care given your child(ren) during the hours you are working as a provider, yourself.

Type of Income	Gross Income	How Often	Expenses	Will this income continue?	Name of person who gets this money
CHILD CARE INCOME **How many children?** _____	$		$	☐ Yes ☐ No ☐ Unknown	

Please complete the following information about the days and hours spent working for this income.

Day	Start Time	End Time	Start Time	End Time
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				

Please list all of your business expenses:

Type of Expense:	Amount of Expense:	How Often*
1.	$	
2.	$	
3.	$	
4.	$	
5.	$	
6.	$	
7.	$	

* How often (weekly, biweekly, bi-monthly, monthly, quarterly, etc.)?

- All expenses must be documented with receipts or other verification.
- Allowable business expenses include household items, wear and tear on household furnishings, the increased cost of utilities, special equipment furnished by the provider for the express use of children in child care, etc.
- When a business is carried on at home, no part of the overhead is considered a business expense.
- A standard deduction of $32/week per child is permitted as deductible child care business expenses. Providers may deduct this weekly amount for every enrolled child with verified payments for child care services. No receipts or other verification is needed when taking the standard deduction. Providers may not take a deduction for their own children.
- For providers who can document expenses in excess of the standard deduction of $32/week per child, actual allowable expenses will be considered. The provider choosing to itemize actual expenses is required to provide an itemized list of allowable expenses for the most recent one-month period of care and receipts for each allowable expense on the list.

For each type of income listed above, include proof of gross income earned and related expenses, if any.

10. UNEARNED INCOME: Do you or any member of your household have any other income? ☐ Yes ☐ No

List all other income below. These are a few examples of types of income. Use the 'Other' category for types of income not listed. 'Other' may include Adoption Subsidy, Gifts/Prizes/Inheritance/Lottery, Retirement Benefits, Trust Funds, VA benefits, etc.

TYPE OF INCOME	AMOUNT	HOW OFTEN	WILL THIS INCOME CONTINUE?	NAME OF PERSON WHO RECEIVES THIS MONEY
UNEMPLOYMENT BENEFITS	$		☐ Yes ☐ No ☐ Unknown	
TEMPORARY DISABILITY (TDI)	$		☐ Yes ☐ No ☐ Unknown	
CHILD SUPPORT	$		☐ Yes ☐ No ☐ Unknown	
ALIMONY	$		☐ Yes ☐ No ☐ Unknown	
WORKERS' COMPENSATION	$		☐ Yes ☐ No ☐ Unknown	
VETERANS BENEFITS	$		☐ Yes ☐ No ☐ Unknown	
SSI	$		☐ Yes ☐ No ☐ Unknown	
RSDI	$		☐ Yes ☐ No ☐ Unknown	
ALIEN SPONSORSHIP	$		☐ Yes ☐ No ☐ Unknown	**Name and Address of Sponsor:**
INTEREST/ DIVIDENDS	$		☐ Yes ☐ No ☐ Unknown	
OTHER: _____	$		☐ Yes ☐ No ☐ Unknown	
OTHER: _____	$		☐ Yes ☐ No ☐ Unknown	
OTHER: _____	$		☐ Yes ☐ No ☐ Unknown	

Please send a copy of proof of income you receive (for example, check or award letter).

11. RESOURCES: Do you, your spouse, or any other person in your household, own any resource such as those listed below? ☐ Yes ☐ No

Liquid resources are defined as any interest(s) in property in the form of cash or other financial instruments or accounts, which are readily convertible to cash or cash equivalents. These include, but are not limited to: cash, bank, credit union or other financial institution savings, checking and money market accounts, certificates of deposit or other time deposits, stocks, bonds, mutual funds, and other similar financial instruments or accounts.

These do not include educational savings accounts, plans, or programs; retirement accounts, plans, or programs; or accounts held jointly with another adult, not including a spouse, living outside the same household but only to the extent the applicant/recipient family documents the funds are from sources owned by the other adult living outside the household, plus the proportionate share of any interest, dividend, or capital gains thereon.

If more than one line is needed for one of the categories below, please use the spaces marked 'Other,' for those additional accounts. If needed, please copy the chart below and attach on a separate page.

TYPE OF RESOURCE	AMOUNT/VALUE	ACCOUNT NUMBER	NAME & ADDRESS OF FINANCIAL INSTITUTION	NAME OF PERSON WHO OWNS THIS RESOURCE
CASH	$			
BANK or CREDIT UNION ACCOUNTS	$	_____ ☐Savg ☐Check		
BANK or CREDIT UNION ACCOUNTS	$	_____ ☐Savg ☐Check		
BANK or CREDIT UNION ACCOUNTS	$	_____ ☐Savg ☐Check		
MONEY MARKET ACCT or CERTIFICATE of DEPOSIT	$	_____ ☐MMkt ☐CDep		
STOCKS/BONDS	$			
MUTUAL FUNDS	$			
OTHER _____	$			
OTHER _____	$			

For each resource listed above, include proof of value of that resource in the form of bank statements, etc. If you have questions about how to verify your resource(s), please call your Child Care Social Worker at 222-7000.

12. RENTAL INCOME: Do you or anyone in your household have income from rental property? ☐ Yes ☐ No

Type of Income	Gross Income	How Often	Expenses	Will this income continue?	Name of person who gets this money
RENTAL INCOME How many units? _____	$		$	☐ Yes ☐ No ☐ Unknown	

For each type of income listed above, include proof of gross income earned and related expenses, if any.

13. ROOM/BOARD INCOME: Do you or anyone in your household have income from providing a room and/or board in your home? ☐ Yes ☐ No

Type of Income	Gross Income	How Often	Expenses	Will this income continue?	Name of person who gets this money
ROOMER/BOARDER How many meals per day? __ Room only? ☐ Yes ☐ No	$		$	☐ Yes ☐ No ☐ Unknown	

For each type of income listed above, include proof of gross income earned and related expenses, if any.

14. DISABILITY OF PARENT: Does the parent who is not working have a disability that makes him/her unable to care for the child(ren)? ☐ Yes ☐ No

If yes, complete the boxes about each person.

Last Name	First	Initial	Medical Problem (describe)
Last Name	First	Initial	Medical Problem (describe)

Verification of this medical condition will be required. DHS will provide you with a form that needs to be completed and signed by a family doctor and returned to the office.

15. DISABILITY OF CHILD: Are you requesting child care for a child with a disability? ☐ Yes ☐ No

If yes, complete the boxes about each child.

Last Name	First	Initial	Medical Problem (describe)
Last Name	First	Initial	Medical Problem (describe)

Verification of this medical condition will be required. DHS will provide you with a form that needs to be completed and signed by a family doctor and returned to the office.

16. ASSC PARTICIPATION: Are you under 21, and do not have a high school diploma? If so, are you participating in an ASSC (Adolescent Self-Sufficiency Collaborative) Program? ☐ Yes ☐ No

If Yes, which ASSC program? _____

Please include a letter from your ASSC program that indicates that you are currently active with ASSC.

17. **REQUESTING HOURS FOR CHILD CARE:**

Please fill out the table below indicating when you need child care services. If both parents are involved in activity(s), you should request care for those hours that neither parent is available to care for your child(ren). Then, please answer the questions at the bottom so that we have a better understanding of your child care need.

Enter hours per day for each child needing care (In-School hours are not allowable as Hours in Care)	SUNDAY From: To:	MONDAY From: To:	TUESDAY From: To:	WEDNESDAY From: To:	THURSDAY From: To:	FRIDAY From: To:	SATURDAY From: To:
Child's Name: _____							
Child's Name: _____							
Child's Name: _____							
Child's Name: _____							

Will the hours that you requested above change on a regular basis due to the changing or variable hours of your activity schedule ? ☐ Yes ☐ No

If yes, what is the approximate number of hours that you participate in your activity per week? _____

How long is your commute from your child care provider to your activity? _____

Do you need before school care (before 9:00 am) for any of your school age children? ☐ Yes ☐ No

Will the hours requested above require the use of more than one provider? (for example, a different provider on the weekend or at nights) ☐ Yes ☐ No

NON-DISCRIMINATION NOTICE

In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), and Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.); the Food Stamp Act; the Age Discrimination Act of 1975; the U.S. Department of Health and Human Services implementing regulations (45 C.F.R. Parts 80 and 84), and the U.S. Department of Education implementing regulations (34 C.F.R. Parts 104 and 106); and the U.S. Department of Agriculture, Food and Nutrition Services (7 C.F.R. 272.6), the Rhode Island Department of Human Services (DHS) does not discriminate on the basis of race, color, national origin (Limited English Proficiency persons), age, sex, disability, religion, or political beliefs, in acceptance for or provision of services, employment or treatment in its educational and other programs and activities. Under other provisions of applicable law, DHS does not discriminate on the basis of sexual orientation, gender identity or expression.

For further information about these laws, regulations and DHS's discrimination complaint procedures for resolution of complaints of discrimination, contact DHS at 600 New London Avenue #57, Cranston, RI 02920, telephone number 462-2130 (TDD 711 or 462-6239). The Community Relations Liaison Officer is the coordinator for implementation of Title VI; and the Office of Rehabilitative Services (ORS) Administrator or his/her designee is the coordinator for implementation of the Title IX, Section 504, and ADA. The Director of DHS or his/her designee has the overall responsibility for DHS's civil rights compliance.

Inquiries concerning the application of Title IX and 34 C.F.R. Part 106 to DHS may also be made directly to the Assistant Secretary for Civil Rights, U.S. Department of Education, Washington, D.C. 20202 or the Office for Civil Rights, U.S. Department of Education, Region I, Boston MA 02109.

RIGHTS AND RESPONSIBILITIES
Of Applicants/Recipients of Child Care Assistance Program

RIGHTS

You have a RIGHT to request, and if found eligible, to receive Child Care Assistance based on policies and standards established under State laws.

You have a right to be provided information in a format you can understand, and to be treated with courtesy, consideration and respect.

You have a RIGHT to appeal and to receive a prompt Hearing before a DHS Appeals Officer if you are dissatisfied with any Department decision, or if the Department delays in making a decision. You may be represented by a lawyer or any other person you select to appear on your behalf. Hearing forms, on which you may file your complaint, are available in every local and state office. You must request a hearing within thirty (30) days from the date you receive a written notice for Child Care Assistance.

You have a RIGHT to refuse to provide information on your racial/ethnic heritage.

You have a RIGHT to confidentiality. The Department uses information about you and other members of your household only for purposes directly related to the administration of the programs and in compliance of the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information. The Department does not release information about you or other members of your household without your consent except as provided in Rhode Island General Laws 40-6-12 and 40-6-12.1, and regulations set forth in the DHS and Child Care Assistance Policy Manuals. Any person found guilty of violating the provisions of Rhode Island General Laws 40-6-12 shall be deemed guilty of a misdemeanor. Violators are subject to a maximum fine of two hundred dollars ($200), or imprisonment of up to six (6) months, or both.

RESPONSIBILITIES

You have a RESPONSIBILITY to supply the Department with accurate information about your income, resources and living arrangements.

You have a RESPONSIBILITY to tell us immediately (within ten (10) days) of any changes in your income, resources, family composition, or any other changes that affect your household.

You have a RESPONSIBILITY to provide Social Security numbers for yourself and your household, or to apply, if you are required to, for them as a condition of eligibility. Your Social Security number, as well as the Social Security numbers of all members of your household for whom you receive assistance, will be used in computer matching with the Department of Labor and Training, the Social Security Administration, the Internal Revenue Service, the Food and Nutrition Services, and other governmental and non-governmental entities authorized by law, regulation or contract, and they will be subject to verification by Federal, State, and local officials. The income and eligibility information obtained from these agencies will be used to make sure your household is eligible for and receiving the correct amount of Child Care Assistance. Social Security numbers are also used to prevent a person or family from receiving duplicate benefits under any program, to make mass changes in federal benefits easier to implement, and to determine the accuracy and reliability of information given to the Department by applicants for and recipients of assistance.

You have a RESPONSIBILITY to cooperate fully with State and Federal personnel conducting quality control reviews.

You have a RESPONSIBILITY to consent to and cooperate with the Department in establishing paternity, and in establishing and/or enforcing child support and medical support orders for all children in the family, pursuant to Rhode Island General Law, Section 40-5.1-17, and in accordance with Title 15 of the General Laws, as amended, unless found to have good cause for refusing to comply with the requirements of this law. Failure to cooperate with the Office of Child Support Services regarding any child in your family will result in denial or closure of Child Care Assistance for all children in your family.

I understand that pursuant to Rhode Island General Law, Sections 40-6-9, 40-6-10, or 40-8-15, without the necessity of signing any document:

I understand and agree that the DHS office may contact other persons or organizations to obtain the necessary proof of my eligibility and level of benefits.

I understand that this application will serve as authorization to the Department of Human services to obtain from medical providers information that is pertinent to me or any person included in this application for as long as the case remains open. DHS has my consent to use or disclose protected health information for the purposes of treatment, payment and health care operations in accordance with DHS notice of privacy practices.

DHS can use or share information on this application for the administration of DHS programs, as well as the administration of other federally funded assistance programs in accordance with state and federal law, contract and regulation.

DHS can release non-identifying information for research purposes. Any release of identifying information shall be done in accordance with state and federal law.

I understand the questions on this application and the penalty for hiding or giving false information or breaking any of the rules listed in this Penalty Warning.

PENALTIES FOR PERJURY:
I certify under penalty of perjury that my answers are correct, including information about citizenship and alien status, and complete to the best of my knowledge and belief. I know that under the state of Rhode Island General Laws, Section 40-6-15, a maximum fine of $1,000, or imprisonment of up to five (5) years, or both, may be imposed for a person who obtains or attempts to obtain, or aids or abets any person to obtain, public assistance to which s/he is not entitled, or who willfully fails to report income, resources or personal circumstances or increases therein which exceed the amount previously reported.

I CERTIFY, under penalty of perjury, that all of the information contained in this application is true.

Signature of Applicant or Recipient	Date	Signature of Guardian, Conservator or Holder of Power of Attorney	Date
Signature of Spouse or other parent of child(ren)	Date	Signature of Agency Representative	Date